

Division of Health Care Facilities

PRINTED: 03/09/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/01/2017
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF GREENEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET GREENEVILLE, TN 37743			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies. A licensure survey and investigation of complaints #40592, #40569, and #40792 were completed on 3/1/17 at Life Care Center of Greenville. No health deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 002			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DATE FORM

6809

LXX311

3/15/17

If continuation sheet 1 of 1